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PRESIDENT'S MESSAGE

We started this year of AAG activities with a thought provoking and stimulating symposium on the Silver century – prospects and problems, conducted in partnership with COTA-NSW. The aim of the symposium was to discuss the opportunities and challenges arising from population ageing, and the program reflected AAG's important roles in providing leadership in ageing and in setting an agenda for intelligent discourse on ageing issues. The symposium was also a tribute to the late Emeritus Professor Sol Encel. Sol was a fine scholar, an inspiration, and a wonderful friend to many in AAG. He was a much valued member of our Executive committee. Our August 2010 seminar was just part of his ongoing legacy.

This edition of the New South Wales notes includes a tribute to Sol, written by Hal Kendig, celebrating his life, work and influence. We also round up our other many and varied events across the state, starting with the seminar provided by the Gray Andrews Visiting Fellow, Professor Peter Langhorne, and culminating in our NSW Annual Rural Conference. Professor Langhorne's seminar focussed on stroke care and rehabilitation and provided an opportunity for AAG to partner with the NSW Stroke Network. The seminar was organised by the Hunter Chapter of the AAG, and also featured many of the leaders in stroke and aged care that hail from the Hunter Valley and beyond. The Hunter Chapter also presented the annual Gibson oration, with this year's speaker Professor Stephen Leeder taking a timely look at health care reform.

AAG NSW were also privileged to be able to join the Centre for Research on Social Inclusion at Macquarie University to host a presentation by Professor Chris Phillipson on older people and the social inclusion agenda. Professor Phillipson was joined by Professor John Piggott, A/Prof Michael Fine, and Dr Felicity Barr to consider the virtual absence of older people from the social inclusion agenda and ways to foster their inclusion. The seminar was applauded by Tanya Plibersek, Minister for Social Inclusion, who sent a letter of support.

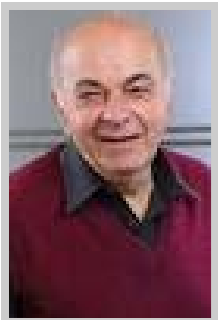
Our 2011 NSW Rural Conference was held on 31 March/1 April at Cessnock, highlighting lessons on care from urban and rural communities. The conference nestled nicely within the AAG's 2011 hot topic on care in the community, and the abstracts are included in this edition of the notes. We enjoyed a great diversity in conference attendees in terms of background, region, and sector. The conference featured an extended morning tea where we invited community groups to join the delegates and to chat about their roles in their various communities. We also enjoyed some excellent presentations, and a number of these "brought people to tears" (in a good way!). Sincere thanks to the planning committee, the speakers, and to everyone else for their help on the days.

Further from home we supported a delegation to the AAGs Darwin event, the Ageing North on: 12&13th August 2010, and the satellite workshop: Growing Old in Aboriginal Communities –A Research and Services Update. We also supported some delegates to the National conference in Tasmania where a great time was had by all.

This will be my last year as President of the NSW Division of AAG. I'd like to thank the AAG NSW Division Executive for wonderful support and enthusiasm during my term as President. It was a most rewarding and enjoyable role, and I hope and expect that we will continue to work together as effectively and enjoyably when I take on the cloak of the National President in October.

It's all very exciting

Julie Byles



Professor Sol Encel (1925-2010)

I am sure you will all share our sadness and sense of loss. Sol was a wonderful intellectual as well as a gentle and caring person. He was a true inspiration to gerontologists across Australia and was an absolute delight to know. Aren't we all so privileged to have had that honour.

Sol will live on for ever in our minds, our work, and our hearts.

Professor Julie Byles

Gerontology and Australian public life lost a leading scholar and champion for older people when Professor Sol Encel died peacefully on the morning of Friday 30 July. He had been working late the previous night completing a major publication on age discrimination in the workforce for National Seniors Australia and the Australian Human Rights Commission. For many months beforehand he had been planning 'The Silver Century: Prospects and Problems' sponsored by the Australian Association of Gerontology (NSW Division) and Council on the Ageing NSW. A few weeks after his sudden death the event was held, with sadness, 'in recognition of the late Emeritus Professor Sol Encel's vision and life work towards a just society'. The day deeply reflected his excellence and commitment and we sorely missed him.

Professor Encel will be celebrated for his major contributions to Australian intellectual life and social commentary. His life's work was shaped by his own experience as a migrant arriving from Poland at the age of four years and his observation of the tragedies of Europe in the 1930s and the progress of Australian post war reconstruction and development. He was deeply affected by the social turmoil of the 1970s and was sought and respected throughout his career as a thoughtful and articulate advocate for vital social causes and disadvantaged people. When Sol spoke on ABC radio – as he did so many times - people listened.

Sol's first career was as the founding father of what then was the new discipline of sociology in Australia. Working originally in political science at the Australian National University during the 1960s he then moved in the 1970s to establish Australia's leading School of Sociology and Anthropology at the University of New South Wales. His book *Australian Society* (1965) laid the foundations for a generation of sociologists. His PhD students flourished under his wise mentoring, meticulous scholarship, and deep knowledge of philosophy and history as well sociology. Sol exemplified the highest values of rigorous and fair enquiry and debate, combined with honesty, humility, and social consciousness.

Sol's second career began in 1991 when he retired from Sociology at the age of 65 years and then took up an honorary appointment at the UNSW Social Policy Research Centre. With Allan Borowski and Elizabeth Ozanne he edited a new set of foundation books *Ageing and Social Policy in Australia* (1997) and then *Longevity and Social Change in Australia* (2007). While he was always actively involved in public and community service, Sol's energies were increasingly directed to ageing with his service on the NSW Ministerial Advisory Committee on Ageing and the Executive of the Australian Association of Gerontology (NSW). His quiet, authoritative words conveyed knowledge and wisdom with good humour and tolerance.

Over the last decade Sol devoted his scholarship and advocacy increasingly to shedding critical light on age discrimination in the workforce. His research found this discrimination to be real, deep, harmful, and based on prejudice rather than fact. To combat ageism he worked closely with Elizabeth Broderick and Priya SaratChandran from the Australian Human Rights Commission, Peter Matwijiw at National Seniors Australia, and Anne-Marie Elias from the Council on the Ageing NSW.

Sol Encel was Australian Gerontology's leading voice and counsel for confronting ageism. He evinced the potential of older people by contributing deeply to public life during his own later life.

Written by Professor Hal Kendig

THE SILVER CENTURY PROSPECTS & PROBLEMS



The Hon Barry Jones (Writer, lawyer, social activist, broadcaster, former Labor politician) reminded us that ageing is not new, but it is becoming more common. Once a notable event, living to a century or beyond is no longer rare. However, he also pointed out that most traditional assumptions about ageing are wrong.

The problem stems from our tendency to lump together notions of the “third” and “fourth” age. The third age refers to people who are no longer in the workforce, but non-the-less independent and productive; the fourth age includes those who are frail and dependent.

He says we make a fundamental error by taking the minority of “frail” older people as typical of the whole body of retired people. We need a “fresh map of life”.

He notes that this idea of an active third age is an anathema to much of government policy and community attitudes. Our general attitude on ageing is about “smoothing the pillow” or slowing down into old age (what Barry terms as a “horizontal policy”), where as it should be a time of “revving up”, or staying active and upright (his “vertical” policy). This from a man for whom Australian legislation was changed to allow him to stay in public office beyond the age of 72 years.

He reminded me of a radio journalist who recently interviewed me, saying: “the baby boomers are about to retire and move into nursing homes” – as if there is nothing in between.

The other problem stems from invalid ideas about how we value and reward labour, roles and time use in our society. Barry asks: “how can we rejoice in and realise the full potential of these added years of life”. When you think about it, increasing proportions of people in the “third age” is not a burden on society, but a huge increase in human capital.

Professor Julie Byles

Australian Association of Gerontology (NSW)
Council on the Ageing NSW

The Silver Century

Prospects & Problems

Was held on Thursday 19th August, 2010

9am — 2.30pm

AAG NSW Annual General Meeting commenced at 2.30pm

Topics covered were:

Housing, Transport & Urban Development—Julian Disney
Employment & Welfare of Older People—Bob Gregory
Mature Age Participation—a whole community—Pino Migliorino

PANEL DISCUSSIONS:

With speakers above & including:
Priya SaratChandran AHRC, Alison Peters NCOS, and
Anthony Brown (AAG)



COTA (NSW)

Council on the Ageing (NSW) Inc
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Missing in Action?



Older People and the Social Inclusion Agenda

Was held on 11th February, 2011

At 9.30 am to 12 pm

Mitchell Theatre, Sydney Mechanics' School
280 Pitt Street Sydney

International Guest Speaker for this event was:

Professor Chris Phillipson (*his only Sydney presentation*)

Professor of Applied Social Studies and Social Gerontology Keele University (UK),
Past President of the British Society of Gerontology

Other Presenters were:

- Prof John Piggott** Director ARC Centre of Excellence in Population Ageing Research
A/Prof Michael Fine Deputy Director Centre for Research on Social Inclusion, Macquarie University.
Prof Julie Byles President Australian Association of Gerontology (NSW Division); Director of the Research Centre for Gender, Health and Ageing, Newcastle University
Dr Felicity Barr President AAG NSW Hunter Valley Chapter

Despite the importance placed on ideals of social inclusion, older Australians are not currently identified as a target group in the *Australian Social Inclusion Agenda*. Older people who are excluded from employment face potential isolation, poverty, ill-health and marginalisation.

Discussions on whether the social inclusion approach provides the right principles of social justice to take on the threats of disadvantage that older people continue to face ensured good strong debate.



Australian Association of Gerontology (NSW)
& Centre for Research on Social Inclusion, Macquarie University





2010 RM Gibson Oration & Dinner

“Reform or reformation? The future for ageing health in the new health vision”.

Was held at 6.30 pm, Wednesday, 30th June 2010

Travelodge Newcastle City
Cnr King and Steel Streets, NEWCASTLE.



Professor Stephen Leeder

AAG Hunter Chapter was pleased to present the 2010 Gibson Oration which was delivered by Prof Stephen Leeder, Professor of Public Health and Community Medicine at the University of Sydney and currently a Director of the Menzies Centre for Health Policy.

Professor Leeder has some controversial views on the COAG health reform agenda and discussed the relevance of the proposed reforms to the care of older people.

Gary Andrews Visiting Fellow

Professor Peter Langhorne

10th November, 2010

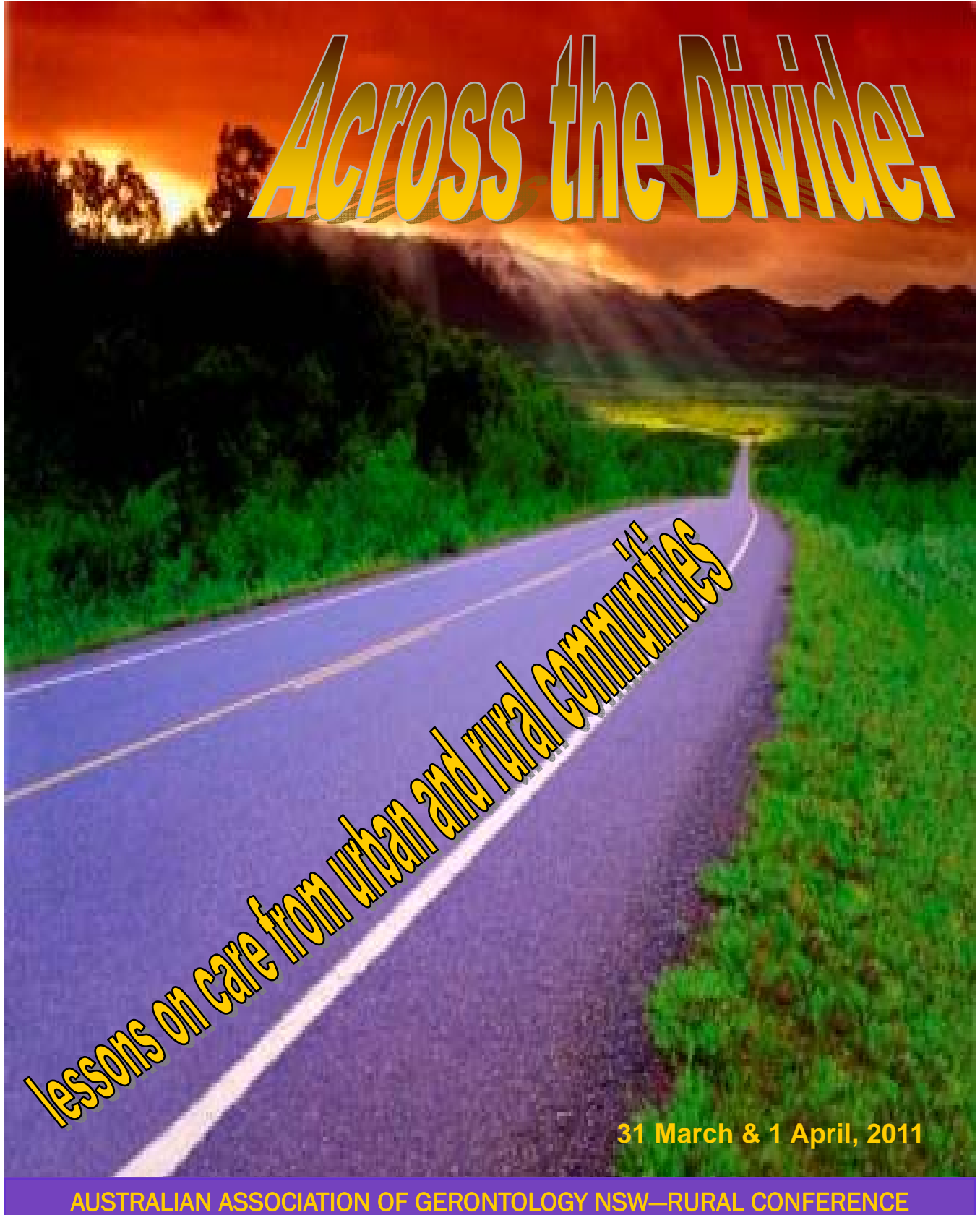
Professor Peter Langhorne visited NSW on 10th November to a seminar at the John Hunter Hospital.

Professor Langhorne is from the University of Glasgow in Scotland. Prof Langhorne's scientific work concerns the effectiveness of different management strategies for stroke patients including service delivery and stroke rehabilitation. His seminar topic was: The future of stroke care: where should the evidence lead us?

The seminar was held in conjunction with the NSW Stroke Network, with other seminar presenters including Prof Chris Levi from the University of Newcastle Research Centre for Brain and Mental Health, and Prof Richard Lindley from Sydney. Stroke Network co-ordinator Dr Michael Pollack conducted an interactive panel session in the afternoon. During the panel discussion, local aged care provider Viv Allanson (past president of Hunter Chapter AAG) highlighted some concerns about transferring modern stroke care practice to residential aged care settings.

Around 70 people attended the face-to-face site at Newcastle's John Hunter Hospital, with another dozen linked by video-conference at sites in Taree and Tamworth. Feedback was very positive from delegates, many of whom were engaged in stroke care teams across the region





Across the Divide

Lessons on care from urban and rural communities

31 March & 1 April, 2011

AUSTRALIAN ASSOCIATION OF GERONTOLOGY NSW—RURAL CONFERENCE

ETHICAL AND MORAL DILEMMAS CARING FOR DYING PEOPLE IN RESIDENTIAL AGED CARE FACILITIES

Ludmilla Sneesby¹

¹Clinical Nurse Consultant in Palliative Care, Department of Palliative Care, Calvary Mater Newcastle Hospital, NSW

Health care professionals encounter ethical and moral dilemmas on a daily basis, particularly those caring for dying patients. A person facing death may be confronted with a myriad of issues, not only personal, physical and psycho-spiritual but also decisions regarding medical treatments. Included are: resuscitation, artificial hydration and provision of nutrition, place of death, and whether to continue or cease active treatment. Never before in the history of mankind have we had so many decisions to make due to longer life expectancies, modern technology and medical advancements.

Residential Aged care Facilities (RACF) have adopted a palliative approach to care and with the growing awareness of Advanced Care Planning (ACP), many RACF now offer ACP on admission. This concept was developed to address decision making at the end of life with the aim of respecting the choice, autonomy, preferences and personal values of the individual in future time of reduced capacity.

Although ACP may have taken place, circumstances arise that challenge our moral and ethical thinking. We gain insight and knowledge from patient case studies as we explore issues that are highly emotive and individualised.

Through a discourse analysis of conversation and interviews of those involved, a greater understanding of end of life decision making may be gained through the eyes of the patient, family, nurse and doctor.

Meeting the challenge - providing contemporary services in a small rural community

Lisa Ralphs¹

¹Community Programs Manager, Presbyterian Aged Care NSW & ACT, Sydney, NSW

The services provided at PAC Apsley Riverview in Walcha provide a snapshot of the range of contemporary services being provided to support independence, socialisation and healthy lifestyles for frail older people living in a rural community.

The small size of towns such as Walcha can make it difficult and expensive to introduce new services to meet the wide range of needs in the community. By building on its existing infrastructure, PAC has been able to introduce flexible services which can be tailored to individual needs and take account of the unique challenges faced by older people who often live on isolated properties and who have limited access to allied health and other services more readily available in metropolitan centres.

Our day respite program incorporates Allied Health services such as Physiotherapy, Podiatry, and Occupational Therapy allowing personalised programs aimed at improving and maintaining the level of functioning of our clients. A range of exercise equipment shared by residents of our hostel and respite recipients allow strength and balance programs to be run to help improve mobility and confidence. Joint activities are run to allow residents and respite recipients to preserve friendships that would otherwise be challenged by distance.

Walcha is a small rural community and our paper explores service development and provision in rural NSW. Rural communities are a microcosm of our cities but without the varied resources larger populations are able to support. Rural services are required to be creative and to meet needs and deal with challenges often unheard of by our city cousins. The presentation also covers our person centred care approach and our focus on independence, healthy lifestyles and social participation to address social and geographical isolation.



THE OLDER PATIENT'S JOURNEY WITH THE SHORT TERM RESIDENTIAL ACCOMMODATION SERVICE (STRAS)

Virginia Tideswell¹, Gay Woodhouse²

¹Residential Aged Care Coordinator – STRAS, Hunter New England Health Service, Belmont, NSW

²Clinical Care Coordinator – STRAS, Hunter New England Health Service, Belmont, NSW

The Short Term Residential Accommodation Service (STRAS) unit, previously known as the Resident Transitional Care Unit, was established in 2003 to provide and coordinate care for older people from five acute care facilities awaiting transfer to residential aged care in the Greater Newcastle Sector, Hunter New England area Health Service. The purpose of the STRAS unit is to provide person centred care for patients who are medically stable and are no longer requiring acute care. The unit was established to promote effective and timely transfer of older patients to a residential care facility at the same time as maintaining person centred care. Person centred care focuses on the establishment of positive relationships that engages the older person and their families to encourage a feeling of well-being (Fazio, 2008).

The STRAS service provides for a seamless transfer of patients from acute care to a residential care facility by ensuring maintenance and improvement of the functional status of the older patient.

The aim of this presentation is to describe the journey of the older patient from acute care to the STRAS unit, residential care and the role of the STRAS team.



MOBILITY OUTCOMES AT BELLINGEN AND MACKSVILLE HOSPITALS

Stephen Downs¹, Pauline Chiarelli²

¹Physiotherapist, Transitional Aged Care Bellingen Hospital, Bellingen, NSW

²Associate Professor, Program Convenor (Bachelor of Physiotherapy), School of Health Sciences, University of Newcastle, Newcastle, NSW

Purpose:

Describe the outcomes for inpatient at Bellingen and Macksville hospitals receiving physiotherapy to improve mobility, in terms of functional balance and discharge destination and to describe the relationship between patient's functional balance assessment and their discharge destination.

Method:

86 patients were described in terms of: age, baseline assessment of Berg Balance Scale (BBS), physiotherapist's expected change in BBS, the presence or absence of various health issues, the presence or absence of a carer, pre-admission accommodation, discharge destination, final BBS and assessment of accuracy of the physiotherapist's initial balance prognosis.

Results:

The inpatient population at these hospitals had wide variation:

Average Age 81.09 (SD 9.74), Average baseline BBS 28/56 (SD 15.9/56) Average Final BBS 31.9/56 (SD 14.86/56). Initial physiotherapist prognosis appear acceptable (average error on BBS 7.49/56). Preadmission, 80 of the participants were community dwelling, 4 were resident in hostel accommodation, 2 in nursing home accommodation. After discharge 64 participants returned to the community, 5 to hostel accommodation, 17 to nursing home accommodation. Three study participants are yet to have their final BBS and discharge destination determined. There was a definite relationship between BBS at discharge and discharge destination.

Coping with change

thoughts on ageing

Ruth Bright¹

¹Fellow of the Australian Association of Gerontology, Wahroonga, NSW

Changes necessarily occur as people age:

- Relationships are lost through the death of friends and relatives,
- or are reduced to long-distance links because of difficulties in travel, especially for those who live in rural areas.
- The body develops problems such as loss (or partial loss) – of hearing, sight, mobility,
- the way of life may also be affected by chronic illness,
- and each person usually finds it harder to care adequately for a household and perhaps even for him/herself.
- Minds become less active – even if we do not develop dementia,
- Financial difficulties may limit the way of life

People's lives may also be affected by changes in the attitudes towards ageing which are experienced in their community, whether urban or rural

How do we cope with changes such as these, whether in helping others (as professionals working in aged care), or in dealing with the changes which occur in our own lives and circumstances?

I shall discuss these questions from a personal and a professional viewpoint, with some consideration of the different factors which affect rural and urban individuals and families.



Aged Care Triage Service, the link to providing the right care in the right place for clients living in residential care within Sydney South West Area Health Service

Debra Donnelly¹

¹Clinical Manager Aged Care and Rehabilitation, Sydney and South West Sydney Local Health Network's, Sydney, NSW

The Aged Care Triage (ACT) service is a partnership between 123 Residential Aged Care Facilities, Division's of General Practice and Sydney South West Area Health.

This service is a single point of access to telephone triage, clinical advice, clinical support and liaison with health services within SSWAHS for clients and staff in residential care and their General Practitioners. The service provides clinical advice and offering appropriate alternate care pathways for clients by facilitating clinical care in the RACF and providing support and education to RACF care staff. This service has the capacity to facilitate and coordinate transfers to the most appropriate ED or to arrange direct admissions within SSWAHS.

This innovative service has improved the health systems capacity in responding to the health needs of the Residential Care community. This flexibility to respond to individual clinical needs enables access to services in the most appropriate care setting.

The development of this service has solidified the existing partnerships with residential care and divisions of general practice within the AHS.

Since the introduction of this service SSWAHS estimates 3483 of inappropriate presentations to ED's across the AHS have been prevented.



Across the Ethical Divide: Assisting Carers with Sexuality in Residential Care

Elaine White¹, Fran Dumont², Georgene McNeil³

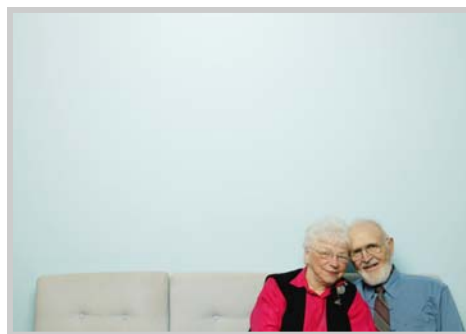
¹Educator, Hunter Dementia Memory & Resource Centre, Alzheimer's Australia, Newcastle, NSW

²Dementia Delirium Clinical Nurse Consultant Acute Care, Hunter New England

Ethical dilemmas often arise when new relationships form in residential settings. Health care staff can become concerned when they see residents forming a liaison with a co-resident who has dementia, even if both parties are widowed. The health care staff might feel they need to protect the residents, feeling that they might be taken advantage of due to impaired decision making and judgment.

The primary carer(s) may experience these concerns as well. It is often the sons or daughters that take exceptions to a new relationship forming. They may feel their parent's capacity to make informed decisions regarding a new relationship is diminished because of their diagnosis of dementia. As a consequence, ethical dilemmas can be created when interventions to terminate a relationship do not take into account the person living with dementia's own wishes. Questions always arise about the capacity of the person living with dementia to make an informed decision to enter into a sexual relationship.

This workshop will explore the ethical dilemmas often originating from misunderstandings and prejudices which challenge the person living with dementia's right to sexual expression. We will also discuss the issues involved for a health care staff member when this ethical dilemma may compromise their duty of care. Discussion will also include the impact of a newly formed sexual relationship on the sons and daughters of the people involved. A case study will be presented to open discussion around these issues.



Happy, Healthy and Wise: Older Country People Lead the Way

Gary Jacobson¹, Marika Kontellis¹

¹Zakumi Consulting Group, Sydney, NSW

Marie is 80 and Jack is 83ⁱ. For the past 25 years they have been leading their small town's efforts in helping their own who have been affected by cancer. Holding events, raising funds and directly supporting locals seems to be a way of life.

During 2009 and 2010, Marika and Gary (the presenters of this interactive workshop) had the privilege of working with over 1000 older, country volunteers focussed on making a difference in their community. Their engagement, leadership and sense of community demonstrates leading edge "care" capacity building practice in local communities across NSW.

The stories that Marika and Gary will share will be linked to the "*What makes us happy?*" report that brings together a decade of findings from the Australian Unity Well-being Indexⁱⁱ – a partnership between Australian Unity and Deakin University. The high "care" factor of many of these older country based volunteers not only help others, but may make those who care, happier and healthier too.

The interactive workshop will also provide some helpful strategies to help engage older people in better caring for themselves through caring for others.

ⁱ Not their real names

ⁱⁱ Authored by Professor Bob Cummins, Deakin University

Consumer Perspectives on Aged Care Reform

Jo Root¹, Ian Yates²

¹National Policy Manager, COTA Australia, Canberra, ACT

²Chief Executive, COTA Australia, Canberra, ACT

Australia is about to enter a period of significant aged care reform with the Council of Australian Government's (COAG) having agreed on the Commonwealth taking responsibility for all aged care and the Productivity Commission's Inquiry into Caring for Older Australians due to report by June 2011. This paper looks at the proposed reforms from a consumer perspective. COTA Australia, in its submission to the Productivity Commission identified five things that older people have consistently identified as wanting from the aged care system. These were support to remain living as independently as possible for as long as possible; certainty that they can access support and care when they need it, greater choice and control of what services they use and who provides them; high quality support and care services and better recognition of informal carers as part of the care team. We also highlighted the differing needs of older people living in rural and remote Australia and stressed the need for flexible approaches. In this paper we will assess whether or not the COAG reforms and the recommendations in the draft report from the Productivity Commission deliver on those consumer expectations particularly for people living in regional and rural Australia.

The Getting Together Project: Volunteers Promoting Wellbeing Amongst Isolated Older Adults in Deprived Urban and Rural Areas in Scotland

Pauline Banks¹, Y Simpson¹, H Kane¹, C Calder², S Comrie³, K Brennan⁴, A Kydd¹

¹University of the West of Scotland

²Seniors Together

³Voice of Experience Forum

⁴NHS Lanarkshire

Background: Although many people are now living longer and healthier lives, research shows that loneliness is a common problem. In Scotland the proportion of the population living in rural areas is increasing. However, research suggests that older people in rural areas may be at risk of social exclusion. Volunteering, which has been found to be associated with increased satisfaction amongst older volunteers, has been successfully harnessed to support a range of individuals at risk of isolation.

Aim: To ascertain whether the quality of life of isolated older people can be improved through working with older volunteers.

Method: Volunteers (aged 50+) and isolated older people (aged 65+) were identified and recruited through a variety of channels. Volunteers fulfilled two roles, volunteer and research participant. Following a training programme volunteers were matched with an older person for a period of six months in order to identify potential health or social problems and negotiate potential solutions. A member of the research team carried out one-to-one interviews with volunteers and older people on joining the project, and again once they had worked together for six months. Interviews with older people explored factors implicated in them becoming isolated initially and their experiences of the project. Volunteer interviews focused on experience of volunteering. Both volunteers and older people completed a number of standardised measures of health and wellbeing.

Findings: Discussion focuses on the challenge of identifying both volunteers and isolated older people, and lesson learned from the project. Differences between rural and urban areas are highlighted.



Community Care Reform: Lessons From The Past

Paul Sadler¹

¹CEO, Presbyterian Aged Care NSW & ACT, Sydney, NSW

A review of the history of HACC and other community care programs over the past 25 years will highlight some **strengths**, such as:

- Significant growth of community services – in volume and variety, and in better reaching special needs groups
- A culture of community development and collaboration, local solutions and distributed network of service providers
- Examples of creativity and innovation, such as the community care demonstration projects, Community Options programs, better practice / IMPACT initiatives
- Increased professionalisation of services and technical support
- Generally bipartisan political support, leading to policy stability and predictable growth.

It will also expose some **weaknesses**, such as:

- Commonwealth / State bickering and buck-passing
- The resulting slow (some might say glacial) pace of change through 9 jurisdictions nationally and anywhere from 3-5 NSW government departments (including across the health / community divide)
- Parochialism by some service providers
- Limitations of narrow service types and output-based funding methodologies, and the lack of evidence on effectiveness
- The exclusions from HACC (e.g. we don't do rehabilitation, post acute care, palliative care, transport access to residential care services)
- Learning the lessons from the introduction of competitive tendering.

So how might community care be reconfigured once HACC transfers to the Australian Government? On the plus side, there is the opportunity to create a single national community care program that has a consistent policy across the care continuum. This can include proper integration of packaged care and basic care, and finding the right place for consumer-directed care and the preventative, wellness and enabling models.

But a 'brave new world' of a bigger Canberra-based national program needs to keep the historical strengths of community care, such as its community development component, its planned and predictable growth, and its diverse range of services and local innovations. There will be challenges making sure the system works across the new ageing and disability divide at age 65, and across the aged care, primary care and specialist chronic disease programs in the community. And we also have to anticipate what may happen, both opportunities and risks, through industry consolidation, both of service providers and, in NSW, of HACC peak bodies.

Ageing and Intellectual Disability – The Rural Perspective

Stuart Wark^{1,2}, Rafat Hussain², Helen Edwards³

¹The Ascent Group, Armidale, NSW

²The School of Rural Medicine, University of New England, Armidale, NSW

³The School of Education, University of New England, Armidale, NSW

In recent years, a combination of factors have seen life expectancies for people with disabilities increase dramatically. While this improvement is naturally a very desirable outcome, it is resulting in a new crisis; how are a substantial number of people with an intellectual disability going to be supported as they start experiencing age-related issues? The majority of research so far focussed upon people with disabilities but little information is available regarding how support organisations and carers deal with these issues.

The purpose of this study was to gain an understanding from on-the-ground staff within rural and remote areas regarding what they perceive to be the most pressing issues facing them as they support people with disabilities who are ageing. From these findings, it was possible to determine the training and support needs for staff through their own identification of priority areas. The two-fold goals of the project are to provide rural organisations with support and training models regarding concurrent ageing with intellectual disability, as well as to seek assistance from relevant government departments specifically for specialised programs aimed at addressing any shortcomings or areas of weakness.

The current paper outlines the Delphi research model used to gain the ideas and thoughts of disability support workers with respect to ageing issues. The recommendations of the research for both Government and disability organisations are presented, with particular emphasis upon the support and training that can be implemented to assist rural disability support workers to work more effectively, efficiently and safely.



Caring for Groups with Particular Needs

Paul McDonald¹, Greg Shapter¹, Fiona McKenzie¹

¹Uniting Care Ageing, Western Region, Broken Hill, NSW

Our clients live in Far West NSW and our care service is based in Broken Hill reaching both the Menindee and Ivanhoe communities over 300 kms away. Two main services are available for our Indigenous and Non Indigenous clients.

Approximately 40% of our clients are Indigenous receiving Community Care packages delivered in their homes by predominantly Indigenous staff who are trained to deliver person centred care in the form of Community Aged Care Packages (CACP), Extended Aged Care At Home Packages (EACH) EACH Dementia and Department of Veterans Affairs Home Care (DVA) and private care. We also provide an Aboriginal and Torres Strait Island specific Day Care Centre service in Broken Hill.

Our care service is committed to providing supportive culturally appropriate and competent inspired care to the Indigenous community, this commitment entails large distances of travel for our staff, considered case management to service the physical and cultural and family needs of the clients. Our service delivery is often challenged by difficult situations, either physical or demographic catering for people who have significant high health and social justice needs.

We intend to present oral and pictorial case studies that demonstrate the difficulties encountered with remote service delivery and the successes that can be achieved by working in partnership with families and communities to enable people to remain at home in their communities for as long as possible.

UnitingCare Ageing is committed to providing and delivering services in remote and rural areas that constantly raise challenges for person centered care delivery and staff commitment. This presentation will link in with the conference theme in the following areas:

1. UnitingCare Ageing has initiated positive outcomes for people from rural and remote areas – 2 individual case studies available. Remote, Indigenous, financially disadvantaged EACH and EACHD clients.

and:-

2. From a consumer perspective: Insuring the best possible care in rural communities supporting social participation initiatives addressing men's social and geographical isolation – 1 case study available.

Taking the Freeze out of Parkinson's Disease: Lessons Learnt from Progressive Parkinson's Education Groups

Angela Johnson¹, Alex Tait², Merridie Rees³, Kathy Bullen⁴

¹Clinical Coordinator, Rankin Park Centre, Hunter New England Health

²Speech Pathologist, Rankin Park Centre, Hunter New England Health

³Clinical Nurse Consultant Aged Care/Rehabilitation Rankin Park Centre, Hunter New England Health

⁴Service Manager, Rankin Park Centre, Hunter New England Health

Aim: Rankin Park Day Hospital's multidisciplinary team has reviewed, evaluated and formalised the Parkinson's disease (PD) program that has been evolving since the 1980's. This process was attended in conjunction with the NSW Parkinson's Association, its members and carers.

Relevance: The availability of this type of program for PD is minimal in the Hunter area. Evaluations from previous PD groups highlighted changes required. The multidisciplinary team met to evaluate the program and investigate recent innovations in PD exercise and individualised goal setting using the Canadian Occupational Performance Measure (COPM).

Six groups are held yearly. Eight patients and their carers attend for an eight-week program. The program includes a one-hour education session and one-hour exercise session.

Methods: Data previously collected included TUG, leg strength, fear of falling and MMSE. The program is being extended to include a multidisciplinary team client review at a pre-admission clinic, the involvement of a Geriatrician in case conference and an update of all education sessions with particular consideration given to the psychosocial components. Specific exercise stations and physiotherapy staff enhancement to the exercise component of the program will assist in individualising the program. Each client receives an information folder containing relevant exercise and education material

Future Direction: Day Hospital will review the pre- and post-data for 2011 to establish effectiveness. The changes planned for 2011 are an enhancement of the program to implement best practice to support people living with Parkinson's disease.

CARING FOR THE CULTURALLY ISOLATED

Maria Stephanou¹

¹Manager, NSW Transcultural Aged Care Service (TACS), Croydon, NSW

‘Culturally isolated’ aged care recipients include people from culturally and linguistically diverse (CALD) backgrounds, those from aboriginal communities and persons with sexual preferences not considered ‘mainstream’. Some of the issues affecting culturally isolated people in care are similar in terms of social isolation and acceptance; but the characteristics and particular needs of each group are quite different. This presentation focuses on CALD residential and community aged care recipients and proposes solutions for addressing the isolation factor.

In NSW the vast majority of migrants have settled in metropolitan Sydney (72% of the 70+ CALD population, ABS 2006) with smaller cohorts in Illawarra and the Hunter and very low figures in some rural areas. There are exceptions. In rural centres such as Griffith, we find historical settlements of specific groups. There is also a sprinkling of earlier and now rapidly ageing migrants across the state.

Cultural isolation can arise in both city and rural environments. The difficulties include communication barriers as a result of low English proficiency or loss of capacity, distance from spiritual support and lack of social networks.

The person-centred approach seems the most appropriate strategy for addressing the aged care needs of the culturally isolated. This involves researching the cultural background of the care recipient, learning about their life journey using communication aids and finding out about resources and valuable contacts. Government programs such as the Partners in Culturally Appropriate Care and the Community Partners Program are funded to assist service providers to deliver culturally appropriate care.



Mature Aged Driving for Today

Judy Lindsay¹, Di McArtney², Angela McGrath³

¹Regional Telecross Coordinator, Australian Red Cross, Broadmeadow, NSW

²Manager Newcastle/Gosford Veterans' Affairs Network, Department of Veterans' Affairs

³Road Safety Officer, Newcastle City Council

Senior driver safety is receiving increased attention as the population ages. According to the Bureau of Statistics the number of people in NSW 65 and over will grow from 990,000 to 1.8million by 2030. The number of drivers in this age group is projected to double in this time. There are many and varied issues which confront the mature aged driver in what is clearly a far busier and more complex roadway system today than when they obtained their licences.

From the 2009 NRMA "Years Ahead Driving Program," evaluations by attending participants identified the following issues:

- * High levels of anxiety preparing for the RTA 85 yr old driving test
- * Knowledge regarding current road rules, in particular round-a-bouts and merging traffic
- * Other road users, in particular young drivers
- * Medications.....how it affects driver ability
- * Driving conditions.....night time, poor lighting, wet weather conditions

From these evaluations the Hunter Older Driver Steering Committee identified the need to establish a tool, namely a DVD, that would inform and support older drivers through the driver retirement process.

This 12 minute DVD will be shown as part of this presentation. It aims to help create a better awareness of these issues so that older drivers can make better and more informed decisions about their driving today and in the future. It also aims to raise similar awareness for families, General Practitioners and community members that may enable them to support older drivers by facilitating discussion around driving retirement.



You're Standing Up - How Does That Feel?

Patricia Joyce¹

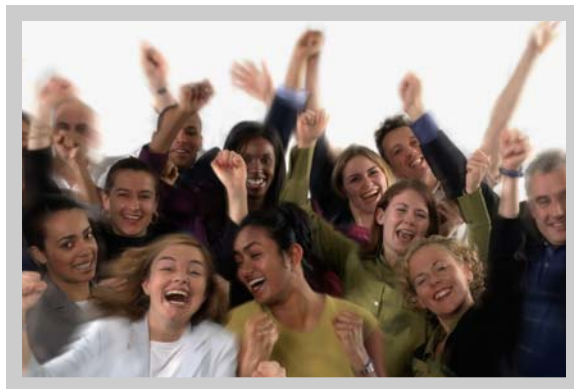
¹Advocate The Aged –care Rights Service Inc, Sydney, NSW

There are over 6,500 people under the age of 65 residing in aged care homes across Australia, including children and young adults. The Aged-care Rights Service Inc, the independent advocacy service in NSW, receives more than 320 calls each year from or on behalf of younger residents, more than 250 of these seeking advocacy.

Advocacy can play a crucial part in the process to raise awareness of rights under The Aged Care Act including the rights that all residents have to appropriate robust therapies, for both young and older residents to improve their quality of life. Any improvement in mobility in turn provides hope for the young person and satisfaction for those caring for them. This positive impact extends to the resident's family, friends, and the wider community.

We believe that a multi-disciplinary approach to rehabilitation of the younger person in an aged care setting can have a positive impact on the person's mobility and physical dexterity. Consequently, self-confidence and attitude whether the person's care needs area results from trauma, stroke, degenerative diseases, mental illness or a failed suicide attempt.

Caring for groups of young people with particular needs is challenging, and we as aged care advocates support care managers, allied health workers and personal care staff who are proactive and forward thinking, getting younger people out of their rooms, involved in activities of their interest and even back on their feet whether in rural or metropolitan settings.



Cooking for 1-2 in the Hunter

Di McArtney¹, Lauren Williams², Anne Hills², Lou Micallef³, Malcolm Scott⁴, Richard Kidd⁴, Christine Kidd⁴

¹Manager, Newcastle & Gosford Veterans' Affairs Network (VAN), Department of Veterans Affairs, Newcastle, NSW

²Nutrition & Dietics, University of Newcastle, Newcastle, NSW

³Ex-Service Organisation (ESO) Volunteer Coordinator, Cooking for 1-2 in the Hunter

⁴ESO Volunteer, Cooking for 1-2 in the Hunter

Cooking for 1-2 is a basic cooking and nutrition program specifically targeted at older veterans and the wider community to combat malnutrition in an ageing population. The program was originally developed in Queensland by Nutrition Australia with funding from the Department of Veterans' Affairs (DVA).

The course provides a hands-on approach with comprehensive tutoring and a cookbook. As a group, all participants prepare a main meal and dessert and then share their meal together. As well as enjoying the health benefits of preparing and eating a nutritious meal, the program provides an excellent opportunity in reducing social isolation. Topics include food hygiene, food safety, budgeting, malnutrition and exercise. Your health and appropriate alcohol intake are also discussed

The program is aimed at:

- members of the veteran and wider community;
- people who have never had the need to cook previously but now for personal reasons find themselves cooking but do not feel they have the skills to do so
- people who live at home who would like to improve their cooking skills;
- people who are a carer or who may become a carer;
- aged men and women who have limited cooking skills.

Cooking for 1-2 in the Hunter was established in 2004 and is a sustainable, accessible and affordable community project. Since 2004, four to seven classes have been held each year in the Hunter region. The project continues to expand into other areas and a further project "Recipe for Life" is currently being developed .



“Aspire to Inspire”—Ensuring Person-Centred Care is a Lived Experience in an Indigenous Community Aged-Care Service, Through a Transformational Practice Development Program

Philip Eldridge¹, Carmel Gibbons², Sue Evans³

¹Regional Coordinating Chaplain, Uniting Care Ageing, South Eastern Region NSW/ACT, Wollongong, NSW

²Area Manager, Uniting Care Ageing, South Eastern Region NSW/ACT, Wollongong, NSW

³Community Care Manager, Uniting Care Ageing, South Eastern Region NSW/ACT, Wollongong, NSW

This presentation will describe the unique challenges, learnings and opportunities for growth that characterise the delivery of a three year collaborative practice development program between The University of Wollongong School of Nursing and Uniting Care Ageing South Eastern Region, in seeking to develop a person centred effective culture for the delivery of aged care services in a rural indigenous community setting. The presentation will focus on the first-hand experiences of ‘Aspire to Inspire’ Program facilitators in working with indigenous staff, clients and elders on the far south coast of NSW, during the first two years of the Program.

Uniting Care Ageing, South Eastern Region is part of a larger organisation; ‘Uniting Care Ageing,’ an arm of the Uniting Church in Australia, which has historic links with the first Australians. This shared history sees UnitingCare Ageing, uniquely placed to understand both the cultural sensitivities, challenges and mutual active learning opportunities that come from partnering with indigenous staff in caring for their elders.

The ‘Aspire to Inspire’ Program, using the Practice Development Model and the Person Centred Framework (McCormack and McCance 2006), has provided the structure for UnitingCare Ageing South Eastern Region to bridge the gap between the theory of its ‘Inspired Care’ Policy and the lived experience of person-centred care in an indigenous setting; including the principles of flexibility, leadership, individuality and diversity, respect, empowerment, decision making, choice, relationships, community, activity, fun and spirituality. This has seen the ‘Aspire’ Program break new ground; making it unique in the over 25 year history of international Practice Development.



Specialist at the Door Step

Dr C Padmakumar¹, K Broadhurst², Dr A Scane³

¹Staff Specialist Geriatrician, Greater Newcastle Cluster, Geriatrician, Rural Hunter ACAT, Newcastle, NSW

²Clinical Coordinator, Rural Hunter ACAT, Lower Hunter Cluster

³Senior Staff Specialist Geriatrician & Clinical Director Greater Newcastle Cluster & Geriatrician Rural Hunter ACAT

The Frail Elderly living in the Rural Hunter are at a considerable disadvantage by being relatively isolated from specialised health care. Rural Hunter ACAT provide an assessment and case management service. They may on occasions alert the General practitioner to the need of a further assessment by a Geriatrician or other Specialist.

The Hunter valley is approximately 23,000sqkms and varies from a metropolitan centre (Newcastle) to rural towns and communities which are over three hours drive from Newcastle. Following GP referral, the Geriatricians attached to the Rural Hunter ACAT (approx 1.3 FTE) provide a Comprehensive Geriatric Assessment (CGA) which includes: clinical assessment; diagnosis of common geriatric syndromes; instituting a management plan and providing advice on care services and or aged care facilities (ACFs) when needed. The Geriatricians provide consultations at the District Hospitals and Multi-purpose services in the Hunter and will see patients in their own homes or visit ACFs as needed.

An overview of the services provided by the Geriatricians over a 1 year period shows the following figures:

979 Hospital consultations (including Reviews); 344 Home Visits; 109 ACF Visits. This involved driving approximately 45000kms by the Geriatricians.

By bringing the Specialist to the Door step of the Elderly in the Rural Hunter, we have described a Model of Care for the Older Person which has got the potential to be emulated elsewhere. Telemedicine, although not yet utilized has the potential to dovetail into this service to enhance it further.

Better Outcomes for Older People in their Communities

Indra Arunachalam¹

¹Manager, Corporate & Financial Services, integratedliving Australia Limited, Muswellbrook, NSW

This presentation looks at how and why the aged and community care sector profile is shifting from a multitude of smaller specialised providers to a consolidated number of larger and more diverse providers in pursuit of achieving better outcomes for older people in their communities.

In Australia, the sector is dominated by the not-for-profit entities that have had a focus on maximising social outcomes, at times at the expense of financial viability. Today, the not-for-profit entities have to balance their social priorities with the reality of scarce economic resources for future viability.

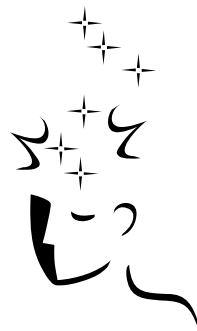
The recently negotiated National Healthcare Agreement is major change facing the sector. Mergers are a possible growth option.

My research has investigated the success factors for mergers in the not-for-profit aged and community care sector. Mixed methodology has been employed in drawing together data from Department of Health and Ageing, Australian Institute of Health and Welfare, Productivity Commission and the Aged and Community Services of NSW & ACT members.

The first part of the presentation will show how the sector has evolved in terms of number of approved providers, services, residential beds and packages over the recent years.

The second part will focus on why consolidation is happening. It will present the main reasons for merger activities, challenges faced and critical factors for consideration in future mergers.

The presentation concludes with a case study of integratedliving Australia as it positions itself to be a growing community care provider in rural and regional communities.



EBPRAC Nutrition and Hydration: Demqol as a Quality of Life Measure

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¹Research Centre for Gender, Health and Ageing, University of Newcastle, Newcastle, NSW

²University of Technology, Sydney, NSW

³University of Queensland, Brisbane, QLD

Objectives: There is good evidence that nutrition improvement can have multiple positive impacts for aged care residents. However, promoting healthcare practice change is complex, and implications for residents' quality of life (QoL) must also be considered, as an important outcome for nutrition improvement and for its own sake. While there is a plethora of measures of QoL, none is demonstrably suitable for this setting. To be most useful, a measure must be brief, psychometrically sound, easy to use, have clinical face validity, and free to use. The DEMQoL tool does well on these essentials, but is not fully tested in practice. This paper explores the utility of DEMQoL as a measure of QoL in residential aged care.

Methods: A Participatory Action Research project, funded by Australian Government Department of Health and Ageing under Encouraging Best Practice in Residential Aged Care (EBPRAC) Program, supported and evaluated implementation of best practice nutrition and hydration in nine NSW aged care facilities. DEMQoL measured resident QoL, for 155 residents, three times across the project. We examined DEMQoL ease of use, internal consistency, association with nutrition status and usefulness.

Results: DEMQoL is easy to use in this setting, has good internal consistency (overall Alpha=0.89) and moderate to good (although non-linear) correlation with measured nutrition ($Rho=-0.38, p<.0001$). However, DEMQoL has equivocal usefulness as a measure of QoL change.

Conclusion: Although performing well on some dimensions, the DEMQoL needs benchmarking in this setting to optimise its usefulness as a QoL measure.

Improving palliative care in Residential Aged Care Facilities

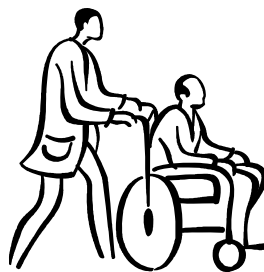
Claudia Giugni¹

¹Manager, NSAP, Palliative Care Australia, Sydney, NSW

As our population ages Residential Aged Care Facilities (RACFs) are caring for an older, frailer population of people with often complex co-morbid conditions. The care of this group is unique and challenging, often managed by a team that predominately consists of assistant nurses. How to ensure equitable access to excellence in palliative care remains a challenge. Palliative Care Australia has developed 'Standards for Providing Quality Palliative Care for all Australians' last revised in 2005. These 13 standards are applicable across aged care, primary care, acute care and specialist care settings.

Implementing these standards across Australia within specialist palliative care services is progressing well with support from the National Standards Assessment Program (NSAP). NSAP provides services with the resources necessary to complete a self-assessment against the 13 national standards and to develop a quality improvement action plan prior to supporting implementation of such plans. A peer mentorship process is available to further support the continuous quality improvement work underway and a collaborative model for change due to commence in April 2011. All work achieved is aligned with relevant accreditation processes. 138 specialist palliative care services across Australia are participating in NSAP with 94 self-assessments and quality improvement action plans completed and submitted online.

This presentation will focus on the key learnings to date from the data provided through NSAP. National and state level data will be provided with a thematic analysis of opportunities for collaborative improvement. Importantly, consultations with aged care providers are underway to modify NSAP for the Residential Aged Care environment with a NSAP Aged Care Reference Group convened in January 2011. An overview of this important work and draft model for implementation will be provided both for information and sector feedback.



The Psychological Cost of Informal Caring in Rural Australia: The ARMHS Cohort

Jacqui Wilson¹, Helen Stain¹ and ARMHS Investigators

¹University of Newcastle, Centre for Rural and Remote Mental Health, Orange, NSW

Background: Unpaid care provided by family and friends is invaluable in many rural communities where formal services and facilities are often lacking¹. Caring however has been associated with adverse physical, psychological, social and financial outcomes for the carer¹. Many of the difficulties confronting carers are exacerbated in rural areas.

Aim: This paper uses baseline measures from the Australian Rural Mental Health Study² to examine the mental health outcomes for rural residents who are engaged in informal caring roles.

Method: Surveys items assessing physical health, psychological symptoms, social support and community connectedness were used in analyses. Participants (124) aged 19–85 years who indicated caring for ≥10 hours per week were matched with 'non-caring' participants on age, gender, and education.

Results: Consistent patterns emerged between carers and non-carers, and between older (≥65) and younger (<65) participants. Carers had significantly poorer mental health, higher levels of alcohol misuse, and were less likely to have someone close to turn to ($p < 0.01$). However the older group had lower levels of psychological distress ($p < 0.01$) and alcohol misuse ($p < 0.05$), and indicated a stronger sense of community than their younger counterparts ($p < 0.05$). Multiple regression analyses demonstrated significant differences in the individual, household and community level predictors of psychological distress between carers (adj. $r^2 = .71$) and non-carers (adj. $r^2 = .35$).

Conclusion: Caring was associated with poorer mental health outcomes, with distinct age patterns emerging. Older carers, although in poorer mental health than their age matched counterparts, appear to be managing better than the younger carers in this sample.

PROGRAMMES TO REDUCING ANXIETY AND DEPRESSION IN WOMEN WHILE IMPROVING COGNITION AND OTHER POSITIVE CHANGES

Margaret Muir¹, Dimity Pond, Anne Graham

¹Discipline of General Practice, University of Newcastle, Newcastle, NSW

There were 65 women from three Aged Care Residential Facilities in Cessnock were invited to participate in two innovative programmes. They were randomly allocated to one of two programmes conducted in small groups within their facility. The programme of Positive GATE-ways (Gestalt Art Therapy Experiential-ways) to Recovery which is based on a basis Person Centred Care and a construct of trauma recovery. The control, GAMES (Gestalt Awareness in Movement Exercises), which increases awareness of the body and how to move more effectively is based on Gestalt Awareness and 'Optimal Flow' (Csikszentmihalyi, 1997) to provide a gradual and effective balance between challenge and anxiety.

These programmes consisted of twelve sessions over six weeks with the aim of the group being the same length but with vastly different content. The focus of this presentation will be quantitative results but some qualitative feedback will also be included. The assessments were made both Pre- and Post the programmes as well as during the individual sessions.

The analysis results, using SPSS, of the Pre-Post results show positive significant statistical and clinical outcomes on anxiety (RAID) depression (CSDD) and cognition (SMMSE). The Program Activity Results (PAR,) of the 'in session' assessments, analyzed also using SPSS, showed positive results on engagement, physical activities social interaction well being the total PAR scores. Both these programmes showed improvement. However there were not major differences between the groups except on attendance and the perception of the women, their relatives and staff !



Art or Exercise Programmes in High Dependency Residential Care: What Insights can be Gained Through the Use of Dementia Care Mapping?

Margaret Muir¹, Dimity Pond, Anne Graham, Ron Sams

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A number of programmes are developed for use in residential facilities but few are subjected to detailed assessment and evaluation. This study has used a variety of quantitative and qualitative assessment tools to evaluate programmes. GATE-ways (Gestalt Art Therapy Experiential-ways) to Recovery and GAMEs (Gestalt Awareness in Movement Exercises) are two 12 session programmes have been assessed are based on Person Centred Care and a construct of trauma recovery. The construct of trauma starts by establishing safety and trust, the learning or relearning of skills, promoting self-esteem and social interaction.

Six women were randomly allocated to both programmes that consisted of twelve sessions of approximately the same length but with vastly different content. One of the qualitative assessments used is Dementia Care Mapping (DCM) is a well researched coded qualitative method of assessment.

DMC mapping enables observations in 5 minute units that enable both the identification of the variety of Behaviour Category Code (BCC) with the degree of well-being or ill-being being shown by the participants. DCM was conducted at the beginning, the middle and at the end of the programme. Both group started from a similar baseline and both groups improved. However it was shown that the GATE-ways programme provided opportunity for a more varied (BCC) for a greater duration with the participants. The art (GATE-ways) group showed a greater increase in 'Well-being'. This positive outcome has prompted GATE-ways being modified for male residents and now GATE-ways has being introduced to other areas of the facility.



WHO IS CARING FOR THE FAMILY?

IDENTIFYING AND INCLUDING THE NEEDS OF FAMILIES AND CARERS IN WORKING WITH OLDER PEOPLE IN HEALTH CARE SETTINGS

Francis Duffy¹

¹Senior Social Worker, St Vincent's Hospital, Sydney, NSW

Working with older people, their families and carers has both therapeutic and practical components. This paper emphasises the importance of working with the families and carers of the elderly in health care settings. This work necessitates involvement beyond practical and medical interventions. Older people, their family and carers often need to work through a range of issues which can include carer stress, family dynamics, challenging behaviours and personality changes in older people with dementia, issues of grief and loss, anxiety, role changes, financial stressors, depression and other mental health issues, etc. Interventions that focus heavily on discharge planning and practical interventions such as arranging home services, respite care, nursing home placements and which subjugates the intra and interpersonal issues of the older person, their carers and families, miss a crucial aspect of the work and this can come at a great cost to outcomes for service users.

Attending to the personal and emotional issues of service users can help to bring clarity to their specific family or system needs, and creates a space that allows appropriate interventions to be identified, and are thus more likely to be sustainable. Unresolved family issues can emerge at this volatile time and social workers have a key role to play with containing and mediating these family volatilities. Handled appropriately the end result can be an improved family system and improved job satisfaction for social workers and other health professionals.



THE ROLE OF MENS SHEDS IN SUCCESSFUL AGEING

Mort Shearer¹

¹National President, The Australian Men's Sheds Association, Port Macquarie, NSW

Men's Sheds are demonstrating that they are able to make a very real and positive contribution to men's health and well-being and, therefore, to successful ageing.

Risk factors which work against successful ageing include isolation, unemployment, depression, poor physical health and significant loss. Men whose risk profile includes combinations of several of these factors are also at increased risk of suicide. The difficulty in reaching out to many of these men is that they will not generally seek support or information from traditional health providers.

Men's Sheds are demonstrating that they can reach out to some of these men in an acceptable way because Sheds are based on the concept that men don't talk face-to-face, they talk shoulder to shoulder. Sheds are therefore set up to offer a safe, friendly environment in which men are given an opportunity to re-connect with other men while working on projects of their own choosing. These activities give them a sense of purpose and build self-esteem, while the supportive environment encourages the men to learn about their own health and well-being.

Mens Sheds are therefore able to build capacity and resilience in this high risk-group and are seen as providing a number of powerful positive factors which encourage successful ageing.

The positive role of Mens Sheds is recognised in the Federal Government's recent National Male Health Policy and in the work of Professor John Macdonald of UWS, A/Prof Barry Golding of NCVET and A/Prof Gary Misan at the Spencer Gulf Rural Health School.



CHARACTERISTICS OF RURAL NSW HOSPITAL SERVICES FOR PEOPLE WITH DEMENTIA

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¹Hospital Dementia Services Project, Ageing and Aged Care Unit, Australian Institute of Health & Welfare, Canberra, ACT

Introduction: The Hospital Dementia Services Project is examining the impact of hospital-based aged care and dementia services on patient outcomes, while accounting for health service mix and aged care provision levels across regions. One component of this project is describing the characteristics of these hospital-based services in rural NSW hospitals.

Method: Surveys of NSW public hospitals were undertaken and the response rate was 76%. The sample comprised 42 urban and 101 rural hospitals. Interviews with key staff at 19 hospitals were also conducted to gather additional information about the operational characteristics of these services and their interaction with the community and residential aged care sectors.

Findings: Preliminary results show that in 2006-07 only four of the 101 rural hospitals had an aged care service and only one had a specialist mental health service for older people. Twenty-nine per cent had access to a geriatrician and 25% had access to a psychogeriatrician for patients with dementia. Preliminary analyses of the qualitative data suggest that factors that may be associated with better patient outcomes include the availability and/or presence of specialist staff such as ASET nurse specialists; packages such as ComPACKS; secure wards; collaborative working relationships between hospital- and community-based services; education and training; and local champions of dementia and delirium.

Conclusions: There is substantial variability in the characteristics of hospital services for people with dementia in rural NSW hospitals. Findings highlight the gaps in the system but also strategies that staff and hospitals have developed to effectively maximise their available resources.

Some Days are Brighter



Margaret Muir¹, Dimity Pond, Anne Graham, Gaynor Heading, Shaye Jewell, Richard Tipping, Susan Kerrigan, Kim Wylie, Danae Jenkins

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'Some days are Brighter' is an edited DVD of an twice a week Art Therapy programme, GATE-ways of six 6 week duration. In this DVD the group of six women from a high dependency residential unit in Cessnock Aged Care Facility are shown participating in this programme. GATE-ways utilise the principles of Positive Psychotherapy, Gestalt and Gestalt Art on a foundation of Person Centred Care. This program has been built around the concept that dementia is a Type III trauma. In the construct of trauma recovery sequential development approach a starts with safety and trust. This is followed by the development or re-development of skills and control that leads to improved self-esteem and finally social intimacy.

This programme has an emphasis on a non-verbal expression and on self-interpretation and provides opportunities for the individuals to share their memories, and experiences, visually and verbally. This innovative approach shows that women in residential care can increase their psychological, physical and social well-being. The vignettes give very clear qualitative responses from all participants including facility and research staff. On completion of the programmes the participants are presented with individualised Visual Diary which incorporated their pictures and stories, or photographs. This provides a tangible record for the resident and insights for family and staff. You will also see the reactions of the women's relatives the 'Graduation Ceremony'. The participants, their relatives, and the facility have asked that the participants not to be de-identified as they are proud of their achievements.

Who Really Provides Care at the End Of Life? Findings From a SA Population Health Survey

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²Southern Adelaide Palliative Services, Repatriation General Hospital, Daw Park, South Australia,

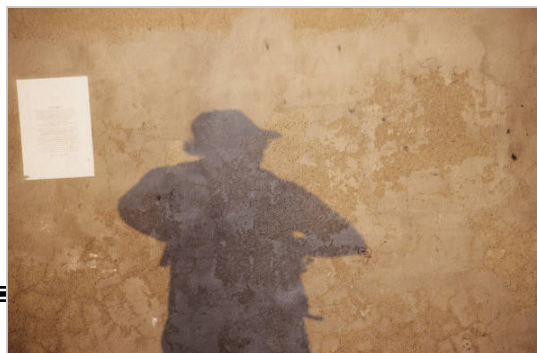
³Division of Medical Oncology, Department of Medicine, Duke University Medical Centre, Durham, North Carolina, USA

Purpose: To provide a comprehensive profile of those people undertaking 'hands on' care of those aged over 65.

Method: The Health Omnibus Survey, an annual face-to-face survey in South Australia, collects health-related data from a representative sample of 4,400 households. Piloted questions included in the 2001-2007 Health Omnibus surveys addressed death of a loved one, caregiving provided, impact of caregiving, and caregiver characteristics.

Results: A cohort of active caregivers that is, those providing daily or intermittent 'hands on' care was identified amongst a bereaved population. The spousal relationship overall accounted for 13% rising to 32% for those aged 65-74 and 54% of those over 75 years. The very old also cared for siblings and other relatives (20%). One quarter of those aged 65-74 provided 'hands on' care for friends. Regression analyses confirmed friends as caregivers as a predictor of home death (OR 1.73 CI 1.15-2.87). In general, 22% of the deceased died at home, 45% in an acute hospital, 16% in a hospice, and 16% in a residential aged care facility (RACF). Almost one third of the aged undertook 'hands on' care for 2- 4 years for a number of life limiting diseases: cancer, lung diseases, end stage heart and renal failure. Only 54% of those aged over 75 used specialist palliative care services. Unmet financial needs were very low but 18% of those aged 65-74 years indicated they could have had more assistance with their emotional needs. Younger people, males and females in equal proportion, also contributed 'hands on' care for the aged signally a changed ratio in the gender of active caregivers.

Conclusion: The age undertake substantial levels of 'hands on' care for those needing it at the end of life and do so quite for extended lengths of time. They may not fully utilise services available.



DECISION-MAKING FOR END OF LIFE CARE AND PALLIATIVE CARE

Jacqui Culver¹

¹CNC / Project Manager, Hunter Collaborative Palliative Dementia Care Framework Project (HCPDCF), Hunter New England Area Health Network, New Lambton, NSW

This session will present a simple advance care communication tool between either residential or community aged care and acute care for people with advanced dementia.

The tool (MOLST) combines a simple diagnostic profile with a medical order regarding life sustaining treatments. It is a one page / double-sided document adapted from an American model (POLST).

This initiative allows for individual information about a person status in the dementia disease trajectory to be quickly accessed by the acute care physician and nursing staff, it prevents hasty acute interventions on admission to an acute facility; it can also prevent hospital admission where locum doctors are unclear of patient history. The tool facilitates transition through emergency departments as it provides a clear and concise medical order that can support the person and their families wishes for treatment and care.

Introduced and modified with feedback to the current Version 7, the MOLST is now widely accepted and has provided some excellent outcomes. This tool provides the treating physician and nursing staff with instant information regarding end of life decisions along with the GP's signed medical order to support that decision making alongside the sign off from the person responsible / appointed guardian.

The MOLST can be used anywhere in community and residential care to make sure that relevant information from the Advance Care Plan related to emergency or acute intervention in advance dementia is readily available, clearly observable and legally sound.



DEMENTIA AND RETIREMENT FROM DRIVING: PEOPLE WITH DEMENTIA AND THEIR CARERS CRITIQUE AVAILABLE TOOLS

Victoria Traynor¹, Cathie Andrew², Don Iverson³

¹Aged and Dementia Care Postgraduate Programme Co-ordinator and Academic Director, NSW and ACT Dementia Training Study Centre, School of Nursing, Midwifery & Indigenous Health, University of Wollongong

² University of Wollongong, Occupational Health and Safety Officer, University of Wollongong and Master of Science by Research candidate, School of Nursing, Midwifery & Indigenous Health, University of Wollongong

³Pro Vice-Chancellor (Health), University of Wollongong

Background: Driving is a complex task demanding cognitive and physical skills which can be compromised by dementia. Some people are reluctant to accept decisions made about the need to retire from driving. This study sought to identify appropriate elements to include in a decisional support resource to enhance acceptance of potential driving retirement for drivers with dementia.

Method: A qualitative study with current drivers over 55 and was one of a very few to include the views of people with dementia. Participants were recruited using newsletter and newspaper notices and clinical contacts. Data collection consisted of one-to-one and group interviews. Content analysis was used to generate themes and In-vivo was used to manage the analysis.

Findings: A total of 20 interviews were undertaken. Participants (n=15) included men and women (40 and 60 percent respectively) and people with dementia (n=2). The focus of this presentation is their views about published resources claiming to help people with dementia and carers to make decisions about continuing driving (n=5). Participants explained contrasts between the resources: readability; information provision; thoughtful or and confronting and ignoring subjectivity or decision or sensitive.

Conclusion: This study contributes important knowledge informed by consumers and potential consumers regarding appropriate inclusions for a decisional support resource for drivers with dementia making decisions regarding driving retirement. Further quantitative research evaluating the effectiveness of using a decisional support resource to enhance acceptance of driving retirement is recommended.



What do People Think About the Community Program “Healthy Living For Seniors”?

A Qualitative Study With Clients, Families, Staff and Stakeholders

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Healthy Living for Seniors is a centre-based day program for frail older adults living in the community. The program is designed to support the health and wellbeing of older adults through providing activities and services that enhance social participation, independence, and quality of life. The service is provided in partnership with the Uniting Church in 11 locations throughout the Lake Macquarie and Central Coast regions.

As part of an evaluation of the Healthy Living for Seniors program, we conducted a qualitative study exploring the views and experiences of clients, families, staff, volunteers and community stakeholders from six centres located in the Lake Macquarie and Central Coast areas. Semi-structured, face-to-face interviews were conducted. Participants were asked about what they liked about the program, whether or not it was meeting their needs, and how it could be improved. The interviews were audio-taped and transcribed verbatim. Thematic analyses were facilitated using QSR NVivo8.

To date, 38 interviews have been conducted with clients (n=13), carers or family members of clients (n=7), staff (n=10), volunteers (n=4) and community stakeholders (n=4). Formal qualitative analyses are currently underway. Preliminary findings suggest that the social aspects of the program were highly valued by the majority of respondents. The program was seen to provide companionship and “lift the spirits” of those who attend. The feedback provided will improve the Healthy Living for Seniors program so that it continues to meet the needs of frail older adults and their families living in the community.

Evaluation of an Integrated Hands-Free Communications System in Residential Aged Care

David Brous¹

¹Impact Consulting Group, Melbourne, Victoria

Samarinda Lodge is a not-for-profit residential facility in Ashburton, in Melbourne. Staffing consists of 75 permanent, part time and casual personnel caring for up to 40 residents with a mixture of high and low care needs.

Several factors contributed to the implementation of a new communications system:

- ✦ poor communications due to mobile workers providing care behind closed doors;
- ✦ the need for staff and residents to communicate for assistance;
- ✦ acknowledgment that messages were not transferred immediately;
- ✦ resident being left alone whilst staff sought assistance to deal with that resident's needs;
- ✦ lack of economies of scale for the operation of a 40 bed facility; and

recognition that more than 70 per cent of operational costs are staffing costs.

Generally, multiple members of staff contribute to the care of residents, both in clinical and auxiliary roles. Many messages pass between staff during a working day. A significant issue occurs when a resident waits for 5 – 10 minutes for care staff to respond to his/her call.

The resulting anxiety, especially with residents in early dementia, can lead to staff spending an additional time settling the resident and managing their behaviour.

Samarinda has implemented **Vocera**, a wireless voice-activated communications device, worn as a badge, used primarily in hospitals and industry for contacting mobile staff in buildings. It is supported by Cisco communications infrastructure.

A pilot project integrated and implemented the technology components in three stages:

Stage 1: installing a wireless network throughout the facility, with a server to support the communications software and carry data to laptops on mobile trolleys used by nurses, doctors and allied health professionals to record and access all resident clinical information;

Stage 2: integrating an Internet Protocol (IP) based telephony system for residents and staff, transmitting voice and other information over a data network; and

Stage 3: integration of the nurse call system into the wireless communications badge and the telephone system.

Reducing the National Injury Prevention Divide in Australia

Patsy Bourke¹, Beth Fuller², Richard Franklin³

¹ Hunter New England Population Health, Tamworth, NSW ² University of Newcastle, NSW ³ Royal Life Saving Society, Australia

Aim: In Australia, injury is a significant issue, with a rising falls related trend among older people. Injury prevention was recognised as a national health priority in 1986. However there is not a robust Australian platform commensurate with this public health burden. This paper indicates successes and identifies the need for investment across the broader injury prevention spectrum.

Methods: Current action:

The Australian Injury Plan provides the best practice evidence, current actions and required action.

The Public Health Association of Australia (PHAA) in partnership with the Australian Injury Prevention Association advocates national injury prevention action.

The National Injury Prevention Working Group is mandated only to address Falls Injury Prevention.

Results:

The need for strategic direction and commensurate funding is urgently required.

There are divides between researchers and practitioners, rural and metro, old and young, and different injury issues (such as road safety and burns)

The PHAA has adopted resolutions to support national action. Policy updates relate to *Fall Injury Prevention in Older People* and *Injury Prevention*. Comments are welcome from the AAG.

National best practice documents have been developed for Falls Injury Prevention.

Conclusion:

An effective sustainable injury coalition is required for which the current Australian health reform agenda can be utilised. Collaboration does work, but requires appropriate investment.



**UNIVERSITY PRIZE WINNERS
AAG NSW Division Prize of \$150
for Outstanding Studentship in Gerontology 2010**

This year AAG NSW awarded two university prizes- University of Wollongong and Charles Sturt University.

University of Wollongong: Elsy Brammesan



Elsy Brammesan receiving her award from the Dean of the Faculty, Professor Patrick Crookes

Charles Sturt University: Christine Lyttelton



FINANCIAL ASSISTANCE AWARDS

\$500 to attend the National Conference - Hobart November 2010

Virginia Simpson-Young, Sandra Bateman, Irena Veljanova

\$130 to attend the ERA Conference—Newcastle October, 2010

Sandra Bateman

Thankyou:

We thank Professor Hal Kendig and Dr Helen Creasey—for their invaluable experience and input into our executive over the past year.

Welcome:

We welcome Dr Vasi Naganathan and Sarah Fogg to the 2011/2012 Executive Committee.

Congratulations:

Congratulations to Taylor Dong on the birth of her baby girl—Sophie Firenze Gal

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